Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Public Report

Report Issue Date: March 6, 2025
Inspection Number: 2025-1554-0001
Inspection Type: Critical Incident
Licensee: The Corporation of Haldimand County
Long Term Care Home and City: Grandview Lodge / Dunnville, Dunnville

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 25-27, 2025 and March 4-6, 2025
The inspection occurred offsite on the following date: February 28, 2025

The following intakes were inspected:

- Intake: #00136362 - Critical Incident (CI) related to infection prevention and control (IPAC).
- Intake: #00137008 - CI related to falls prevention and management.
- Intake: #00133518 - CI related to prevention of abuse and neglect.
- Intake: #00134175 - CI related to prevention of abuse and neglect.
- The following intakes were completed in this inspection:
    - Intake: #00132856, CI; Intake: #00134777, CI; Intake: #00135499, CI; Intake: #00138113, CI; Intake: #00138690, CI, all related to IPAC.
    - Intake: #00131269, CI; Intake: #00132214, CI; Intake: #00132841, CI, all related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that a resident's right to have their choice respected was followed by a staff member when they did not comply with the resident's specified request on a specified date.

Sources: Home's investigation notes and interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care had set out their planned care related to their responsive behaviours prior to a specified date. Both the Director of Nursing (DON) and Associate Director of Nursing (ADON) acknowledged that the resident's responsive behaviours, triggers, and interventions should have been care planned as per their responsive behaviour program when the resident's behaviours were initially identified.

Sources: A resident's clinical records, Risk Management of the Defensive Resident Policy, and interviews with the DON and ADON.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure a resident was protected from verbal abuse by a staff member.

Ontario Regulation (O. Reg.) 246/22, section (s.) 2, defines verbal abuse as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.”

A staff member verbally abused a resident by belittling the resident and their needs when the resident asked for care and the staff made a comment that upset the resident.

Sources: Home's investigation notes and interview with staff.

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that the procedures for cleaning and disinfection in accordance with manufacturer's specification using a low level disinfectant in accordance with evidence-based practice for contact surfaces were implemented.

In accordance with O.Reg. 246/22, s. 11(1)(b) the licensee was required to ensure that the home's "Extra Cleaning During Outbreaks Policy" was fully implemented and complied with. Specifically, to ensure that the home utilized the proper approved disinfectant for outbreaks and additional precaution rooms. On a specified date, a staff member was observed not using the approved disinfectant for two resident rooms on additional precautions.

Sources: Observations, Extra Cleaning During Outbreaks Policy, and interviews with IPAC Lead and staff.

WRITTEN NOTIFICATION: Infection prevention and control

program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, revised September 2023, was implemented. Specifically, under section 9.1, a staff member failed to wear a specified personal protective equipment (PPE) when they entered two resident rooms on additional precautions on a specified date.

Sources: Observations and interview with staff.